UNIT UPDATE

Missouri Department of Health and Senior Services
Unit of Home Care and Rehabilitative Standards

Volume 05-2 – October 2005

THIS INFORMATION SHOULD BE DIRECTED TO THE MANAGEMENT STAFF OF YOUR AGENCY

A MESSAGE FROM LISA COOTS, ADMINISTRATOR

WELCOME TO THE FIRST UNIT UPDATE TO BE SENT VIA EMAIL

It is my hope that the administrators will disseminate this information to all appropriate staff. When our unit initiated this web directory for all the providers that are regulated under the Unit of Home Care and Rehabilitative Standards, your agency/ clinic was contacted and asked that we be given the administrator's email address for this purpose. Some of you also gave us one or two other contacts at the agency, which was fine. We are anticipating that this information will end up in the hands of those who will forward it to the appropriate staff.

Many times when the surveyors are out on survey they are approached with questions. They, in turn, reference the Unit Updates. I have been informed many of the field staff haven't seen these publications in the past. We have all the Unit Updates and former Bureau Talk on our web site for easy access; please continue to access them at www.dhss.mo.gov/HomeCare/. Once on the web site right click on the 6th bullet, *publications*.

Our unit continues to appreciate the support of our providers. It is our intention to continue to provide this newsletter quarterly via email.

As always if there are any questions, please don't hesitate to give me a call at 573-751-6336.

HOME HEALTH SURVEY CYCLE GONE

The Centers for Medicare & Medicaid Services, (CMS) has developed the Survey Mission & Priority Document, previously known as the Budget Call Letter. This document assists the states in determining how many Medicare surveys they need to complete for each fiscal year and gives the states guidelines to assist in prioritizing their workload.
In the past, home health agencies (HHAs) were surveyed according to the flexible survey cycle as determined by specific criteria outlined in the State Operations Manual (SOM) at 2195 (Guidelines for Determining Survey Frequency). Starting with this new fiscal year, October 1, 2005, that portion of the SOM has been deleted. The surveyors will no longer place home health agencies on a 12, 24 or 36 month survey cycle.

There are now four tiers for (HHA) surveys.

Tier 1, the highest priority rating, assures HHAs are surveyed at least every 36 months.
Tier 2 consist of a list of HHAs that have been identified by CMS using an algorithm they developed to identify those HHAs that are at greatest risk of failing to provide quality care. CMS has provided each state with a list of agencies in both Tier 1 and Tier 2.
Tier 3 has no criteria.
Tier 4 promotes additional surveys sufficient to ensure that ultimately 50% of all HHAs are surveyed each year, 24-month average.

HOSPICE, OPT, and CORF SURVEYS

Tier 1: CMS has none listed.
Tier 2 consists of surveying 5% of each provider type.
Tier 3 consists of each provider type receiving a Medicare survey every 8 years.
Tier 4 consists of each provider type receiving a Medicare survey at least every 6 years.

It is the intention of the unit to complete a licensure survey for each hospice this new fiscal year.

OPT and CORF UPDATES

Per S&C-05-45, here is the official release of changes to the State Operations Manual pertaining to Appendix E "Providers of Outpatient Physical Therapy or Outpatient Speech Language Pathology (OPT/OSP) Services," and Appendix K-"Comprehensive Outpatient Rehabilitation Facilities"

The purpose of this revision to Chapter 2, Appendix E, and Appendix K is to delete material, provide clarifying instructions and surveyor guidance for regulations, add deficiency tags, and regulation language to the Appendices. In addition, Sections 2292B and C were combined under Section 2292B in Chapter 2.

Please see link below for a downloadable copy.

http://www.cms.hhs.gov/manuals/pm_trans/R13SOM.pdf

EDL UPDATE

Effective October 1, 2005 the Department of Health & Senior Services has available for your use a secure link, located at: **http://www.dhss.mo.gov/EDL/** to provide access to the quarterly Employee Disqualification List (EDL) update. The quarterly update lists individuals added and deleted from the EDL during July, August and September of 2005. Both additions and deletions are available in two reports: one organized alphabetically by last name and the other organized numerically by social security number.

In order to access either the quarterly updates or to perform EDL checks through one of the automated EDL systems, an employee of an agency must have user ID and password access. If your agency does not already have employees with access to the EDL automated systems, such access may be obtained by clicking on and completing an 'Access Request Form (DDP-137)' at the website address listed above. Each agency may have up to three employees with access. After access is obtained, click on 'Check EDL' to either perform an EDL check or to view the quarterly update.

Quarterly updates will be available at the website four times a year. In January of 2006, the annual EDL report will also be available. The annual EDL report will list all the individuals whose names were on the EDL on December 31, 2005. The quarterly reports can then be used to update the annual EDL report and to determine if any of your agency's current employees have been added to the EDL since the initial pre-employment check.

Please contact Greg Steinbeck in the Department's EDL Unit at 573-522-2449 for assistance if you have questions about performing EDL checks or accessing the quarterly update.

GENERAL INFORMATION

- When the person responsible for encoding the OASIS Data in an agency

changes, the agency needs to contact Melissa Hall at 573/522-8421.

- For any questions related to the Expedited Appeal Notice call Lorelei Schieferdecker at Primaris. Her number is 800/735-6776 ext 155.

Remember…it is the responsibility of the agency to assure that any contracted staff providing services in the home must meet the same regulatory requirements for Criminal Background Checks as the agency's direct employees.

Our web site is: www.dhss.mo.gov/HomeCare

HOSPICE ISSUES

Q. A patient in the hospital is to be discharged. The patient meets the criteria for hospice and the patient, family and physician want the patient admitted to hospice. The patient requires pain and symptom control that cannot be managed in the home. Can the hospice agency admit the patient to their hospice program and transfer his level of care from "hospital inpatient" to "hospice inpatient" while he/she is still in the hospital?

A. Yes, as long as the: 1) the patient's status is **no** longer considered "inpatient" through the hospital and the level of care is changed to reflect a hospice inpatient level of care 2) the agency has a contract with the hospital 3) the patient meets the criteria for **general inpatient hospice care** that includes procedures necessary for pain control or chronic symptom management that cannot feasibly be provided in other settings.

Respite care could also be provided for relief of patient caregivers if the hospice is contracted with the hospital for respite care. Please refer to the Federal Register at 418.302 (b)(4) or access the information by logging onto http://www.cms.hhs.gov/manuals/21_hospice/hs200.asp under Eligibility and Coverage 230.1, letter F under covered services.

Q. Who would be contacted if inducement of a patient by a hospice provider is suspected?

A. It is suggested that Sue Jesse Pennington with CMS Regional office in Kansas City be contacted at (816) 426-5783. For suspected fraud call 1-800-hhs-tips (1-800-447-8477).

Q. Can range of skilled nurse visits be used when providing care for a hospice patient?

A. Yes, providing the ongoing plan of care reflects any frequency changes.

Hospices utilizing minor-age persons as volunteers do not need parental consent to check the Family Care Safety Registry.

CMS PLANS FOR TRANSITIONING TO THE NATIONAL PROVIDER IDENTIFIER (NPI) IN THE FEE-FOR SERVICE MEDICARE PROGRAM:

Between May 23, 2005 and January 2, 2006, CMS claims processing systems will accept an existing legacy Medicare number and reject as unprocessable any claim that includes only an NPI.

Beginning January 3, 2006, and through October 1, 2006, CMS systems will accept an existing legacy Medicare number **or** an NPI as long as it is accompanied by an existing legacy Medicare number.

Beginning October 2, 2006, and through May 22, 2007, CMS systems will accept an existing legacy Medicare number **and/or** an NPI. This will allow for 6-7 months of provider testing before only an NPI will be accepted by the Medicare Program on May 23, 2007.

For additional information, to complete an NPI application, and to access educational tools, visit https://nppes.cms.hhs.gov

CMS has contracted with Fox Systems, Inc. to serve as the NPI Enumerator.

The NPI Enumerator is responsible for dealing with health plans and providers on issues relating to unique identification.

The NPI Enumerator may be contacted as follows:

BY PHONE: - 1-800-465-3203 (NPI Toll-Free)
1-800-692-2326 (NPI TTY)
BY E-MAIL AT:
customerservice@npienumerator.com
BY MAIL AT: - NPI Enumerator
PO Box 6059
Fargo, ND 58108-6059

HOME HEALTH UPGRADED NEEDED

January 2006 is the targeted timeframe for new reporting software to be installed. NHs and HHAs need their PCs to meet the minimum requirements listed in Chart 1 by December 31, 2005. Please make sure your providers are made aware of these new system requirements. Some folks were concerned that they should have these types of systems now.

Chart 1 – End User **Minimum** PC system requirements:	
CPU:	Pentium 3, 500 MHz
Memory:	256 Mb
Operating System:	Windows 2000 or XP
Hard Drive:	500 Mb free space
Browser:	Internet Explorer v5.5 SP2

Pentium 3, 500 MHz = Pentium 3 with 500 MHz NOT Pentium with 3,500 MHz (that's a lot of Hzs)

PLAN OF CORRECTIONS

Please make sure to sign and date the federal and state statement of deficiencies.

Our office will no longer accept faxed copies of the plan of correction. You need to mail back the original statement of deficiencies with administrator's signature and date signed.

ANY PLAN OF CORRECTION THAT IS FAXED TO THIS OFFICE WILL BE DISREGARDED. WE NEED TO RECEIVE THE ORIGINAL IN THE MAIL.

MISSOURI ELECTS NOT TO ENTER INTO A WRITTEN RECIPROCAL AGREEMENT

Can Missouri Hospice be approved to provide services across state lines?

In the past, hospices were approved to cross state lines based upon a verbal agreement between the states. However, in May 2004, the State Operation Manual (SOM) was revised requiring states to have a written reciprocal agreement to provide hospice care across state lines.

Missouri has never had a written reciprocal agreement with any state for hospice. It has been decided by the Department of Health & Senior Services, in conjunction with an unanimous vote of the Hospice Advisory Council, that Missouri would not enter into a written reciprocal agreement for hospice care with any state.

In the past, Missouri hospices have been approved to cross state lines & vice versa based upon a verbal agreement. At this time, CMS (the Kansas City Regional Office) has informed our

unit that those hospices approved prior to the revision of the SOM would be allowed to continue those services across state lines. However, no future hospice provider will be approved to do so.

We have 17 hospices that were approved prior to May 2004 to provide hospice services in another bordering state. There are only 4 hospices in Missouri that have a satellite in another state.

IMMUNIZATION SURVEY

The first step to helping your patients "beat the bug" and to help them avoid hospitalization is to determine if they have been vaccinated against flu and pneumonia and offering them information about how to get vaccinated. Under the direction of CMS, Primaris is administering a statewide survey to determine current immunization practices in home health agencies. Based upon survey results, Primaris will assist agencies to incorporate immunization assessments into their admission process. (As always, their assistance is at no charge.) Agencies that complete the survey will receive an Immunization Toolkit with all the information and forms you need to implement an immunization program in your agency.

We encourage you to respond to this survey if you haven't already done so.

The link to the survey is:

http://www.surveymonkey.com/s.asp?u=659551276366

HAPPY FALL!!

From the Staff of the Unit of Home Care and Rehabilitative Standards